ATTENTION

ATTACHED IS CHANGE 64, 6010.50-M, "AUTOMATED DATA PROCESSING AND REPORTING MANUL," DATED DECEMBER 3, 1997.

CHANGE 64 IS BEING ISSUED AHEAD OF CHANGE 63.

CHANGE 63 IS RESERVED FOR FUTURE USE.

YOU MAY POST CHANGE 64 TO YOUR MANUAL UPON RECEIPT.

QUESTIONS SHOULD BE REFERRED TO WILLIAM C. ORCHARD, DIRECTIVES MANAGER, 303-361-1300 OR DSN 943-1300.

ATTENTION

DEPARTMENT OF DEFENSE
TRICARE SUPPORT OFFICE
AURORA, COLORADO 80045-6900

PDR

CHANGE 64
OCHAMPUS 6010.50-M
December 3, 1997

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR AUTOMATED DATA PROCESSING AND REPORTING MANUAL

THE DIRECTOR, OCHAMPUS, HAS AUTHORIZED THE FOLLOWING CHANGE(S) TO OCHAMPUS MANUAL 6010.50-M, REISSUED JULY 1992:

PAGE CHANGE(S): **CHAPTERS 1, 2, 6 and 8**

REMOVE AND INSERT PAGE(S): **(See page 2 of this transmittal)**

SUMMARY OF CHANGE(S): THIS CHANGE PROVIDES THE OPERATIONAL POLICY AND REQUIREMENTS FOR IMPLEMENTATION OF THE FINAL RULE ON CLARIFICATION OF THE CHAMPUS EXCLUSION OF UNPROVEN DRUGS, DEVICES, AND MEDICAL TREATMENTS AND PROCEDURES. THIS PACKAGE ALSO REFLECTS THE 1997 CPT-4 CODE UPDATES. THIS CHANGE IS ISSUED IN CONJUNCTION WITH COM-FI MANUAL CHANGE 99, OPERATIONS MANUAL CHANGE 105 AND POLICY MANUAL CHANGE 23.

EFFECTIVE DATE AND IMPLEMENTATION: UPON DIRECTION OF THE CONTRACTING OFFICER.

Barbara J. Callegos
for Sheila H. Sparkman
Director, Program Development and Evaluation

ATTACHMENT(S): 30 PAGE(S)
DISTRIBUTION: 6010.50-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH THE BASIC DOCUMENT

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 1	
1.V-1 THROUGH 1.V-3	1.V-1 THROUGH 1.V-3
CHAPTER 2	
2.XI-1 & 2.XI-2	2.XI-1 & 2.XI-2
2.F-7 & 2.F-8	2.F-7 & 2.F-8
2.G-5 & 2.G-6	2.G-5 & 2.G-6
2.I-1 & 2.I-2	2.I-1 & 2.I-2
CHAPTER 6	
6.B-1 THROUGH 6.B-17	6.B-1 THROUGH 6.B-17
CHAPTER 8	
8.I-5 & 8.I-6	8.I-5 & 8.I-6

V. PRICING FILE RECORD SUBMISSION

A. General

1. FI/Contractors are required to submit Health Care Pricing Records via electronic media to *TRICARE Support Office (TSO)*. FI/Contractors are required to report applicable pricing data for all medical procedure codes for which a prevailing fee, by report or a conversion amount, has been developed. This must be done for each state in the FI/Contractor's region. This does not apply to unique in-system pricing arrangements or dental (ADA) procedures. FI/Contractors shall not submit national prevailings on pricing file updates to *TSO*. Refer to the Policy Manual, Chapter 13, for requirements. The records contain required information for each procedure code including the state of care, an element identifying the type of procedure code, and detailed pricing information. Separate pricing records are submitted for area prevailing, by report, or conversion data. These data will be used by *TSO* to verify amounts paid on Health Care Service Records. (See ADP Manual, Chapter 2 for element descriptions and record layouts for the pricing and corresponding batch header record). In the following text, the Element Locator Number will be provided in brackets following each element, where applicable.

2. The data must be submitted to *TSO* according to the procedures outlined in Section II. Initial submission of the pricing file must contain all procedures for which a price exists including by report. If the FI/Contractor uses unique internal procedure codes (e.g., further defined DME codes), a hardcopy listing of these codes and the CPT-4/*TSO* approved code each equates to must be submitted to the Contracting Officer's Representative, *TSO*. Additionally, when the Relative Value Unit (RVU) is greater than 99.9, conversion pricing record data for all procedures must be reported via hardcopy listing to POA.

B. Pricing File Reporting Requirements

Pricing records must be reported for logical data relationships. The following rules are to be used in building the Pricing File for reporting to *TSO*.

1. The 'key' to the Pricing File consists of PRICING STATE OR COUNTRY CODE [4-005], PROCEDURE CODE [4-010], CLASS OF PROVIDER [4-020], TYPE OF PRICING SERVICE [4-025], CATEGORY OF CARE FOR CONVERSION FACTOR [4-050], and PRICING PROFILE [4-052]. No duplicates are allowed within this key.

2. Within each PRICING STATE OR COUNTRY CODE, and PRICING PROFILE, the following are the logical relationships for area prevailing records, including Medicare Economic Index (MEI) where applied:

Logical Relationships for Area Prevailing Records

Procedure Code Range	Surgery 10000-69999	Radiology 70000-79999	Pathology 80000-89999	Psychiatry * 90800-90911	All Others
Class of Provider	01,04	01,04	01,04	01,02,03	01,04
Type of Pricing Svc.	04,09	01,02,05	01,02,05	07,08	03

[1] ***Procedure codes 90901-90911 can be reported with CLASS OF PROVIDER CODES 01, 02, 03, AND 04 and TYPE OF PRICING SERVICE CODES 01, 02, 03 and 05, in the psychiatry range. Procedure codes 92820 and 92850 can be reported with CLASS OF PROVIDER CODES 01, 02 and 03 and TYPE OF PRICING SERVICE CODES 07 AND 08.***

NOTE:

CATEGORY OF CARE FOR CONVERSION FACTOR must be blank on all area prevailing pricing records. RELATIVE VALUE UNITS [4-040], CONVERSION FACTOR [4-045], and CONVERSION AMOUNT [4-035] must be zeros.

3. Within each PRICING STATE OR COUNTRY CODE, and PRICING PROFILE, the following are the logical relationships for conversion pricing records, including MEI, where applied:

Logical Relationships for Conversion Pricing Records

Procedure Code Range	Surgery 10000-69999	Radiology 70000-79999	Pathology 80000-89999	Psychiatry 90800-90911	All Others
Class of Provider	01,04	01,04	01,04	01,02,03	01,04
Type of Pricing Svc.	04,09	01,02,05	01,02,05	03	03
Category of Care for Conversion Factor	S,A,B[1]	R,B[1]	P,B[2]	M,B[2]	M,B[2]

[1] ***Within the surgery code range (10000-69999), code 'B' (By Report) can be reported with either code 'A' or 'S' but not both. If 'B' is reported in combination with 'A' or 'S,' the TYPE OF PRICING SERVICE cannot be the same for both pricing records.***

[2] ***Except for the surgery code range (10000-69999), CATEGORY OF CARE FOR CONVERSION FACTOR code 'B' (By Report) cannot be reported with any of the other CATEGORY OF CARE FOR CONVERSION FACTOR codes for a given PROCEDURE CODE.***

NOTE:

RELATIVE VALUE UNITS [4-040], CONVERSION FACTOR [4-045], and CONVERSION AMOUNT [4-035] must be zeros on 'By Report' pricing records.

C. Pricing File Record Maintenance

1. The Pricing File is a dynamic file where records can be added or, when a change is required, records can be modified or inactivated. The FI/Contractor must submit transactions indicating the type of change and updated information. These transactions will be submitted on an as-needed basis. Each group of transaction records must be preceded by a batch header record that identifies the subsequent records as pricing transaction records.

2. The FI/Contractor's initial pricing file is submitted with all ADD transactions. Upon subsequent completion of area prevailing profile update (normally on an annual basis), the complete pricing file is once again submitted, including records for procedures with no change. These files shall be submitted as MODIFY transactions, except for new (ADD) records.

a. ADD Transactions

The TRANSACTION CODE [4-060] must be coded "A" and all required data elements must be included. An ADD cannot be made if the PRICING STATE OR COUNTRY CODE [4-005], PROCEDURE CODE [4-010], CLASS OF PROVIDER [4-020], TYPE OF PRICING SERVICE [4-025], CATEGORY OF CARE FOR CONVERSION FACTOR [4-050], and PRICING PROFILE [4-052] are already on the file.

b. MODIFY Transactions

The TRANSACTION CODE must be coded "M" and all required data elements must be included. A MODIFY will replace the previous record with a new record. Records being replaced will be archived. Historical prices will automatically be stored on the TSO master pricing file. A MODIFY will not be accepted if the PRICING STATE OR COUNTRY CODE, PROCEDURE CODE, CLASS OF PROVIDER, TYPE OF PRICING SERVICE, CATEGORY OF CARE FOR CONVERSION FACTOR, and PRICING PROFILE are not already on the file.

c. INACTIVATE Transactions

The TRANSACTION CODE must be coded "I" and the PRICING STATE OR COUNTRY CODE, PROCEDURE CODE, CLASS OF PROVIDER, TYPE OF PRICING SERVICE, CATEGORY OF CARE FOR CONVERSION FACTOR, and PRICING PROFILE must be coded. These six data elements must match the same fields on the record at TSO to be inactivated. The INACTIVATE process is to be used only when there is an error on any of the above data elements. To correct an error on these six (6) data elements, the incorrect record must be inactivated and the correct record added using two separate transactions.

XI. PRICING RECORD DATA

Data Element Definition

Element Name: **Category of Care for Conversion Factor**

Records/Locator Numbers

Record Name	Locator #	Occurrences	Required
Pricing	4-050	1	Yes[1]

Primary Picture (Format) One (1) alphanumeric character.

Definition Code identifying the type of conversion factor by care type.

Code/Value Specifications

M	Medical Conversion Factor
A	Anesthesia Conversion Factor
R	Radiology Conversion Factor
P	Pathology Conversion Factor
S	Surgical Conversion Factor
B	By report (no conversion factor, no area prevailing)

Algorithm N/A

Subordinate and/or Group Elements

Subordinate	Group
N/A	N/A

Notes and Special Instructions:

[1] ***Must be blank on prevailing records.***

Data Element Definition

Element Name: **Class of *Provider***

Records/Locator Numbers

Record Name	Locator #	Occurrences	Required
Pricing	4-020	1	Yes [1]

Primary Picture (Format) Two (2) alphanumeric digits.

Definition Code to identify those exceptions to requirements governing development of profiles on a non-specialty basis.

Code/Value Specifications

01 Medical, MD, DOs

02 PHDs, Psychologists

03 Social workers, pastoral counselors, marriage and family counselors, mental health counselors and psychiatric nurse practitioners

04 Others not included in '01', '02', '03' or '05'

05 Chiropractor

Algorithm N/A

Subordinate and/or Group Elements

Subordinate	Group
N/A	N/A

Notes and Special Instructions:

[1] ***Must be used when different prevailing fees or conversion amounts are developed for different classes of providers. If developed for only one class of provider, report only in appropriate class.***

Figure 2-F-6 CPT-4 Code Exceptions

Description of Procedures	Level I Codes
The following CPT-4 codes shall not be used when submitting payment records to TSO.	
Anesthesia Codes:	00100 - 01999 (except 01996) 99100 - 99140

NOTE:

FI/Contractors shall report the surgery procedures as appropriate with the provider specialty coded as "anesthesiology" (05) or "anesthetist" (80) as appropriate. A "0" or a "1" must be coded in the Number of Services field. This field must be coded as "1" on all RPM = Blank or H initial submission **payment records**. *FI/Contractors shall request specific information concerning pricing from the providers, however, pricing units are not to be submitted on payment records.*

Figure 2-F-7 Mental Health Partial Hospitalization Procedure Codes

Description of Procedure	Level III Codes
Outpatient services provided in a group setting by a Substance Use Disorder Rehabilitation Facility.	*90808*
Partial Hospitalization, all-inclusive per diem payment for alcohol rehabilitation, 6 hours or more	92891
Partial Hospitalization, all-inclusive per diem payment for alcohol rehabilitation, 3-5 hours (half day program)	92892
Partial Hospitalization, Night Time Care (reimbursement not to exceed amount allowed for half day)	92893
Psychiatric Partial Hospitalization, all inclusive per diem payment of nonsubstance abuse partial hospitalization programs of 6 hours or more	92898
Psychiatric Partial Hospital, all-inclusive per diem payment of nonsubstance abuse programs of 3 - 5 hours, (half-day program)	92899

NOTE: The only other service that may be cost-shared, in addition to these codes is the one hour of psychotherapy per day for individual or family therapy (not to exceed five per week) performed by authorized mental health professionals not employed by or contracted with the partial hospitalization facility.

Codes	Major/Sub-Category (Continued)	
	6	Post ICU
	7	Burn Care
	8	Trauma
	9	Other Intensive Care
21X	**Coronary Care**	
	Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.	
	Subcategory	
	0	General Classification
	1	Myocardial Infarction
	2	Pulmonary Care
	3	Heart Transplant
	4	Post - CCU
	9	Other Coronary Care
22X	**Special Charges**	
	Charges incurred during an inpatient stay or on a daily basis for certain services.	
	Subcategory	
	0	General Classification
	1	Admission Charge
	2	Technical Support Charge
	3	U.R. Service Charge
	4	Late Discharge, Medically Necessary
	9	Other Special Charges
23X	**Incremental Nursing Charge Rate**	
	Charge for nursing service assessed in addition to room and board.	
	Subcategory	
	0	General Classification

Codes	Major/Sub-Category (Continued)	
	1	Nursery
	2	OB
	3	ICU
	4	CCU
	5	Hospice
	9	Other
24X	**All Inclusive Ancillary**	
	A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.	
	Subcategory	
	0	General Classification
	9	Other Inclusive Ancillary
25X	**Pharmacy**	
	Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of licensed pharmacist.	
	Subcategory	
	0	General classification
	1	Generic Drugs
	2	Non-Generic Drugs
	3	Take Home Drug
	4	Less Than Effective Drugs (Valid Through 3/31/90)
	4	Drugs Incident to Other Diagnostic Services (Effective 4/1/90)
	5	Drugs Incident to Radiology
I	6	*Unproven* Drugs
	7	Non-Prescription
	8	IV Solutions
	9	Other Pharmacy

Addendum I

UB-82 and UB-92 Conversion Table - To Be Used for Reporting Non-Institutional HCSRs

Revenue Code	Description	CPT/HCPCS Procedure Codes
The revenue codes listed below are authorized by the National Uniform Billing Committee. See the National Uniform Billing Data Element specifications for the UB-82 or UB-92, Form Locator 51 for UB-82, Form Locator 42 for UB-92. The codes are required for reporting to *TSO*, but do not indicate *TRICARE* payment policy. Refer to the CHAMPUS Regulation, the Policy Manual, COM-FI, or Operations Manual to determine the *TRICARE* payment policy. The appropriate CPT/HCPCS codes are to be used when available.		
001-239	**Not Valid for Reporting**	
24X	**All Inclusive Ancillary**	
240	General Classification	99088
249	Other Inclusive Ancillary	99088
25X	**Pharmacy**	
250	General Classification	Use appropriate CPT/HCPCS codes. If one is not available, use 99088.
251	Generic Drugs	
252	Non-Generic Drugs	
253	Take Home Drug	
254	Drugs Incident to Other Diagnostic Services (effective April 1, 1990)	
255	Drugs Incident to Radiology	
256	*Unproven* Drugs	
257	Non-Prescription	
258	IV Solutions	
259	Other Pharmacy	
26X	**IV Therapy**	
260	General Classification	Use appropriate CPT/HCPCS codes. If one is not available, use 99088.
261	Infusion Pump	
262	IV Therapy/Pharmacy Services	
263	IV Therapy/Drug/Supply Delivery	

Revenue Code	Description	CPT/HCPCS Procedure Codes
264	IV Therapy/Supplies	
269	Other IV Therapy	
27X	**Medical/Surgical Supplies and Devices**	
270	General Classification	Use appropriate *CPT/HCPCS* codes. If one is not available, use 99070.
271	Non-Sterile Supply	
272	Sterile Supply	
273	Take Home Supplies	
274	Prosthetic/Orthotic Devices	
275	Pacemaker	
276	Intraocular Lens	
277	Oxygen - Take Home	
278	Other Implants	
279	Other Supplies/Devices	
28X	**Oncology**	
280	General Classification	99088
289	Other Oncology	99088
29X	**Durable Medical Equipment (other than renal)**	
290	General Classification	Use appropriate *CPT/HCPCS* codes. If one is not available, use 99070.
291	Rental	
292	Purchase of New DME	
293	Purchase of Used DME	
294	Supplies/Drugs for DME Effectiveness	
299	Other Equipment	